Bristol Clinical Commissioning Group

Bristol Health & Wellbeing Board

AGENDA ITEM 9

Health Protection Committee

Annual Report 2014

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Report for Information	

1. Purpose of this paper

To provide assurance on behalf of the population of Bristol that there are safe, effective and well-tested plans in place to protect the health of the population.

2. Executive summary

Health Protection seeks to prevent or reduce the harm caused by communicable and non-communicable diseases, and minimise the health impact from environmental hazards. The new health protection duty for local authorities came into force on the 1 April 2013 as part of the Health and Social Care Act 2012 (section 6C Regulations).

The purpose of the Health Protection Committee (HPC) is to provide assurance on behalf of the population of Bristol that there are safe, effective and well-tested plans in place to protect the health of the population. The health protection committee receives reports on communicable diseases, healthcare associated infections, emergency planning, sexual health, environmental health, immunisations and screening. This annual report on the work of the Bristol Health Protection Committee summarises the key issues in Bristol. This report summarises the main areas of work and informs the Health and Wellbeing Board of the issues identified by the expert members of the committee.

3. Context

Health Protection covers communicable disease control, infection prevention and control, emergency planning, sexual health, environmental health, and screening and immunisation programmes. The membership of the Health Protection Committee primarily comprises of representatives of relevant existing health protection groups in/covering Bristol. This includes a number of professional partner members who hold health protection responsibilities.

4. Main body of the report

Please see report below

5. Key risks and opportunities

Please see report below

6. Implications (financial and legal if appropriate)

7. Conclusions

There have been a number of changes in the leadership and delivery of the Health Protection Committee function. Despite these challenges the Health Protection Committee assurance function is established. However, further work is required to strengthen the committee and its assurance framework and build on the successful partnership working.

There have been some successful improvements and outcomes in health protection over the last year, in particular an Ebola exercise and MMR catch up campaign. There are still major challenges, particularly in tackling TB in the city, increasing immunisation rates and reducing variation in health outcomes.

8. Recommendations

- The Board receives the annual report of the Health Protection Committee
- The Board accepts the major issues highlighted in the report
- The Board identifies any additional concerns it has or contributions that it can make
- The Board considers the governance arrangements of the Health Protection Committee in its accountability structures

Index

1 Assurance

1.1 Introduction

Health Protection is a term used to encompass:

- preventing the transmission of infectious diseases;
- prevention, diagnosis and management of infections;
- protection against non-communicable environmental hazards;
- ensure the safety of food, water, air and the general environment;
- managing outbreaks and other incidents which threaten the health of the public;
- emergency planning and resilience.

The new health protection duty of local authorities came into force on the 1st April 2013 as part of the Health and Social Care Act 2012. The overarching duty to protect the health of the population lies with the Secretary of State, and is generally discharged by Public Health England.

1.2 The Health Protection Committee

The purpose of the Bristol Health Protection Committee is to provide assurance on behalf of the population of Bristol that there are safe, effective and well-tested plans in place to protect the health of the population. These plans cover communicable disease control, infection prevention and control, emergency planning, sexual health, environmental health, and screening and immunisation programmes. The membership of the Health Protection Committee primarily comprises of representatives of relevant existing health protection groups in/covering Bristol. This includes a number of professional partner members who hold health protection responsibilities:

- Bristol City Council Public Health;
- Bristol City Council Environmental Health;
- Bristol City Council Civil Protection;
- NHS England Area Team Screening and Immunisations (SCRIMMS);
- Public Health England Centre, Consultant in Communicable Disease Control;
- Bristol Clinical Commissioning Group (DIPC);
- NHS England Area Team Head of Emergency Planning, Resilience and Response (link to Local Health Resilience Partnership;
- Bristol Sexual Health Improvement.

The terms of reference for the Committee were refreshed in September 2014 but subject to review in September 2015. This is due to changes in the leadership and delivery of health protection functions.

1.3 Roles and Responsibilities of agencies in Bristol

The member agencies of the Bristol Health Protection Committee have the following responsibilities in relation to health protection (A full list of agencies is in Appendix A).

1.3.1 The Director of Public Health (Local Authority)

The Director of Public Health is responsible for the Local Authority's contribution to health protection matters, including its role in planning for and responding to incidents that present a threat to the health of the local population. A Consultant in Public Health may be asked to deputise for the Director of Public Health depending on the nature of the response and other professional demands.

1.3.2 Environmental Health

Environmental Health Officers are the front line of health protection work in Unitary and Lower Tier Local Authorities. They provide specialist advice with regard to environmental health hazards; and arrange/undertake environmental investigations including inspections, sampling, testing and reporting results. EHOs support epidemiological investigations by interviewing cases and collecting data and can advise on appropriate and proportional public health control measures, including Local Authority powers under the various Health Protection regulations.

1.3.3 Public Health England

Public Health England is responsible for protecting the nation's health through the nation health protection service, and preparing for public health emergencies, sharing information and expertise with stakeholders including Local Authorities.

1.3.4 NHS England (BNSSSG) and Bristol CCG

NHS England Area Team and Bristol Clinical Commissioning Group are the link to NHS-funded providers of healthcare in the implementation of agreed public health control measures. This may include, for example, the establishment of facilities for screening or mass prophylaxis/vaccination. NHS England and Bristol Clinical Commissioning Group work alongside each other to effectively mobilise NHS resources.

2 Key Issues: Infectious diseases

2.1 Priority area: Foodborne disease

Why is foodborne disease a priority for Bristol?

Food poisoning (food borne disease) is any illness that results from eating contaminated food. Foodborne disease can originate from a variety of different foods and be caused by many different pathogenic organisms at some point in the food chain, between farm and fork. Although the majority of cases in the UK are mild they are unpleasant, result in absences from education or the workplace and place a significant demand on healthcare services. Occasionally foodborne disease can lead to complications or even death.

Access to safe food and water is undoubtedly one of the most fundamental human needs. Latest figures from the Food Standards Agency state that there are over 500,000 cases of food poisoning per year across the UK from identified causes and if the unidentified causes were to be included this figure would more than double.

2.1.1 Where are we now?

Bristol City Council) are required to register or approve food businesses, to inspect them within 28 days of the commencement of food operations, to rate them according to assessed food hazards and risks and operate an inspection programme based on these ratings.

Bristol City Council currently has around 4800 premises on the food premises register. These give rise to an inspection programme of approximately 4000 for the year 2013-14.

Limited In house resources are targeted to the highest risk and non-compliant operations. These are carried out by in house staff who can be authorised to exercise appropriate enforcement powers, such as issue of legal notices requiring improvements and in the most serious cases prosecution.

Due to the large number of food businesses in Bristol, many of those in the medium risk category are out-sourced to a specialised Environmental Health contractor.

2.1.2 Priorities for action 2015-16

- Inspection of highest risk rated premises and new businesses.
- Review of food borne disease in Bristol
- Undertake a service review to identify optimum structure.

2.2 Air Borne - Tuberculosis (TB)

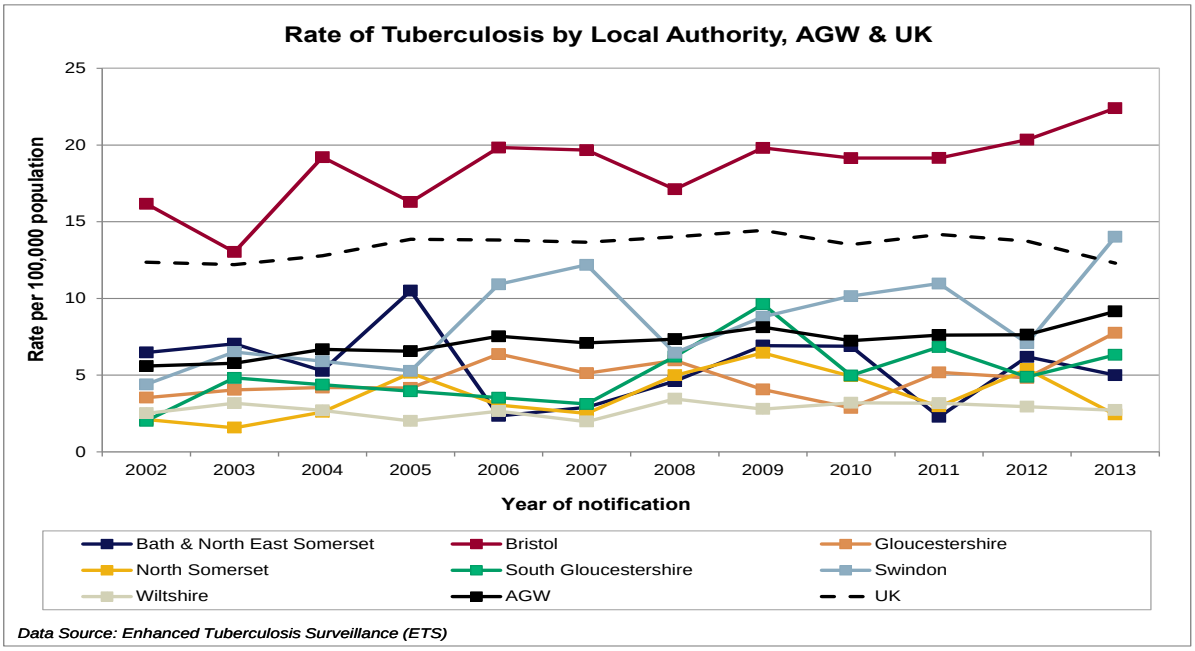
Priority Area: Tuberculosis (TB)

Why is TB a priority for Bristol and the Health Protection Committee?

TB is caused by the bacterium *Mycobacterium tuberculosis.* It is a notifiable disease in the UK.

The annual rate of TB cases per 100,000 population is higher than the UK rate and exceeded 20/100,000 in 2012 and 2013 (Figure 1).

Figure 1: Rate of Tuberculosis by Local Authorities in Avon Gloucestershire and Wiltshire Compared to the UK for the Period 2002 to 2013.



Data Source: Enhanced Tuberculosis Surveillance (ETS)

Despite a small downward trend in annual TB incidence in the UK, Bristol's incidence is increasing.

The number of new cases per year (approximately 120) in the Bristol area places a significant demand on the health care system in terms of clinical management and following up close contacts (contact tracing) to see if they may have been infected. TB contact tracing is the cornerstone in the management of TB as it provides an opportunity to identify any as yet unrecognised cases and also with new smarter testing tools latent TB can be identified (that could effectively wake up and cause active disease) and appropriate action taken to support these people.

Where are we now? (Current position and review of significant activity over the last 12 months)

Strategically, Bristol Local Authority has remained an active partner in the Bristol, North Somerset, South Gloucestershire (BNSSG) TB Prevention and Control Strategy Group. This group comprises several agencies that oversee the overarching

strategic response to preventing and control TB for this catchment area.

During 2014, Public Health England launched a national consultation on a 'Collaborative Tuberculosis Strategy for England' proposing the formation of TB Control Boards, improving early diagnosis and treatment, proposing new-entrant latent TB screening and improving access to the BCG vaccine for those most at risk. The strategy was launched in January 2015.

There is an established TB service operating across Bristol which leads on the clinical management of cases, contact tracing and works with Public Health England in response to more complex TB incidents or outbreak situations. This teams works closely with paediatric services in hospital settings who manage children affected by the disease.

It is important to note that the continued increase in cases poses a risk to current services and the future capacity of these services to provide an adequate response.

Priorities for Action 2015-16: (What are we intending to do during 2015-16?)

1) Establishment of a TB Control Board (building on the BNSSG Prevention and Control Strategy Group) with agreed Terms of Reference and membership to oversee the local implementation of priorities outlined in the National Collaborative Strategy for England. This will be led by Public Health England and the Health Protection Committee will oversee and support its development through existing assurance arrangements.

2) Led by Public Health England in collaboration with Bristol City Council, a Comprehensive Tuberculosis Health Needs Assessment will be undertaken that will further inform local priorities for action to reduce TB incidence and identify opportunities to further improve local TB services.

3) Public Health England in collaboration with Bristol City Council, the production of a local Collaborative TB Strategy to ensure delivery of both national objectives and local priorities as outlined by the Health Needs Assessment.

2.3 Priority area: Hospital acquired or nosocomial infection (HCAI)

2.3.1 Why is this a priority for Bristol?

HCAIs are infections that are acquired as a result of healthcare interventions. HCAIs can be contracted from medical care or treatment in hospital (in-or out-patient), in a social care setting (e.g. nursing homes), or even in the patient's own home (as part of healthcare delivery in the community).

The term HCAI covers a wide range of infections. Many hospitals in the country have participated in voluntary surveillance of key infections for many years. In England it is mandatory for health trusts to report all cases of blood stream infection (bacteremia) caused by Staphylococcus aureus, both methicillin-resistant (MRSA) and methicillin-sensitive (MSSA), glycopeptide-resistant enterococci (GRE), Clostridium difficile infection (CDI) and Escherichia coli (E.coli) to PHE.

Tackling preventable healthcare associated infections is a key priority. Everyone counts: Planning for patients 2013/14 sets a zero tolerance approach to MRSA bloodstream infections. All organisations are expected to achieve zero MRSA bloodstream infections. A post infection review is carried out on each case of MRSA bloodstream infection.

2.3.2 Where are we now?

Bristol has significantly higher number of pre-48 hour MRSA between 2012 and 2014. Initial investigations have revealed key themes that warrant further investigation. Bristol CCG have set up a HCAI group and action plan to address this issues. In addition a MRSA task and finish group has been set up to investigate the levels of MRSA found in intravenous drug users.

2.3.3 Priorities for Action 2015-16

- Investigate the reasons behind the high levels of MRSA within the intravenous drug user population
- Reduce the number of pre-48 hour MRSA

2.4 Sexually Transmitted Infections

2.4.1 Why is sexual health a priority for Bristol?

Sexually transmitted infections (STIs) are passed from one person to another through unprotected sex or genital contact.

There has been a rise in the combined rates of new diagnosis of gonorrhoea and syphilis in the MSM (men who have sex with men) population in Bristol. The rate for Bristol was 869.9 per 100,000 in December 3013, compared to a regional rate of 260.3 per 100,000.

Bristol is close to the threshold of **more than 2 in 1,000 population** having been diagnosed with HIV. Where this is the case BIVA guidelines recommends that primary care and general medical admissions professionals should consider offering and recommending an HIV test when registering and admitting new patients) and that all health practitioners should offer and recommend an HIV test to anyone who has a blood test (regardless of the reason).

2.4.2 Where are we now?

Under the Health and Social Care Act 2012, certain aspects of the public health function of the NHS were transferred to the Local Authority with effect from April 2013. Part of this transfer included the transfer of commissioning responsibilities for open access sexual health services.

A Steering Group, Sexual Health Improvement for Patients and Populations (SHIPP) was set up to look at gaps and areas for improvement in delivery of sexual health services. This group represents those who have an interest in sexual health including; service commissioners, service providers, and academic colleagues. The SHIPP is a functioning Health Integration Team (HIT), one of several HITs which operate under the Bristol Health Partners umbrella.

2.4.3 Priorities for action: The HIT has a number of priority areas for action which include:

- Improving sexual health information systems;
- Chlamydia partner notification pilot in primary care
- HIV Screening and reducing late diagnosis; introducing appropriate screening in primary care
- Consideration of re-commissioning all sexual health services across Bristol and surrounding areas
- Carrying out a sexual health needs assessment and developing a new strategy for Bristol

2.5 Vaccine preventable diseases

Why is this a priority?

Immunisation is one of the most effective ways of protecting against serious infectious diseases. Immunisations are given at various points across a person's lifetime, at times when they are vulnerable to disease for different reasons. Full details of the immunisation schedule can be found in appendix 1. Performance across the range of immunisation programmes is improving, however, coverage is variable and this requires attention to ensure that the local population is protected and does not become susceptible to outbreaks of these diseases

Where are we now? (Current position and review of significant activity over the past 12 months)

Childhood immunisations - Uptake for Hib / MenC at 2 and 5 years, PCV booster at 2 years, MMR at 2 and 5 years and Pre-school booster all remain below the 95%

target. There is, however, improvement in the performance of all of these programmes during 2013/14.

School age immunisations - HPV uptake for 2012/13 was recognised as being poor and immediate action was undertaken to review the service during 2013/14. There has been considerable improvement in the delivery of the programme following this review. A new programme offering Meningitis C vaccine to children in Year 9 has also been successfully introduced during 2014/15.

Whilst uptake continues to improve across all childhood and adolescent programmes, it should be noted that there is considerable variation in coverage within and between the Bristol localities, with rates in Inner City Bristol remaining lower than the area average.

Adult immunisations - The uptake of pertussis vaccine in pregnancy during 2013/14 averaged 61.5%. This was slightly lower than during 2012/13 and further work is required with midwives and GPs to ensure that women are aware of the rationale for the programme and have optimum access to services to be able to receive this in a timely way.

Uptake of pneumococcal vaccine was 71.7% in 2013/14. This is slightly lower than in 2012/13.

The shingles (varicella zoster) vaccine was introduced as a new programme for those aged 70 as of the 1 September 2013. Uptake in 2013/14 was 52.3% for 70 year olds and 53.4% for the additional catch up cohort of 79 year olds.

Bristol achieves uptakes in line with the national average for seasonal flu, with the exception of those with existing medical conditions. Improving uptake in the Under 65 at risk group, amongst pregnant women, Health Care Workers and amongst children have been key priorities for the 2014/15 Seasonal Flu Plan.

Priorities for action 2015/16

- Maintain and improve current performance across all programmes
- Reduce variability in coverage within and between programmes, with a focus on the Inner City Bristol locality
- Implement the extension of the Childhood Flu programme to primary school aged children (Years 1 & 2)
- Implement the Meningitis B programme for children (this will be dependent on successful national negotiations on vaccine costs)

3 Screening

Why is this a priority?

The UK National Screening Committee defines screening as “The process of identifying apparently healthy people who may be at increased risk of a disease or a condition so that they can be offered information, further tests and appropriate treatment to reduce their risk and/or complications arising from the disease or condition.”

There are currently three national cancer screening programmes: breast, bowel and cervical; and eight non-cancer screening programmes: six antenatal and new-born (Fetal Anomaly, Infectious Diseases in Pregnancy, Sickle Cell and Thalassaemia, New-born and Infant Physical Examination, New-born Blood Spot and New-born Hearing) and two young person and adult (Abdominal Aortic Aneurysm and Diabetic Eye).

Cancer screening rates in Bristol are lower than the England and South West average. Only bowel screening rates are above the national target. Compared to comparator towns and cities, Bristol also underperforms against all apart from Salford (and Southampton for breast screening). There are also concerns that coverage rates are declining, in line with experience across the rest of the UK, particularly for breast and cervical screening.

University Hospitals Bristol performs at the higher achievable level for all indicators within the **Antenatal screening** programmes, with the exception of timely referral of hepatitis B positive women for specialist assessment, which is not achieved within acceptable timescales, and timeliness of the Antenatal sickle cell and thalassaemia test which is achieved but at the lower acceptable level

Early in 2013, it was identified that within the **newborn screening** programme there were delays in recording the conclusive results of new-born bloodspot tests on the Child Health Information System (CHIS) within an effective timeframe. Following a full investigation new processes were implemented within the department and in the laboratory. As a result the programme now meets the acceptable target and is on target to meet the higher achievable level. In addition some performance targets have not been met within the newborn hearing screening programme.

In relation to the **adult screening** programmes, the Bristol **Diabetic Eye** Screening programme has achieved all three targets with 80.7% of patients invited attending for screening and 100% of results issued within three weeks of the test and the **Abdominal Aortic Aneurysm** Screening programme continues to perform well.

Priorities for action for 2015/16

- The Screening and Immunisation Team, Bristol City Council Public Health Team and CCG locality chairs to work together to review uptake data by practice and by provider and develop action plans to target areas of poor uptake and coverage for each of the screening programmes
- Develop effective pathways for Hep B diagnosis, treatment and follow up of babies born to Hep B mothers
- Improve the performance of the UHB neonatal hearing screening programme

4 Emergency Planning

Emergencies or Major Incidents can happen at any time of the day or night, and agencies need to be prepared to handle the consequences in order to protect the population of Bristol.

Emergency Planning is the process used to reduce the likelihood of emergencies occurring and to have plans in place to reduce the impact of the emergency on residents and the environment if they do.

The Civil Contingencies Act 2004 outlines the responsibilities of both Category 1 and 2 responders and establishes a statutory framework of how emergencies will be planned for and responded to at a local level

The Local Health Resilience Partnership is a strategic forum for organisations in the local health sector. The LHRP facilitates health sector preparedness and planning for emergencies at Local Resilience Forum (LRF) level.

4.1 Planning for Ebola

4.1.1 Why is Ebola a priority for Bristol and the Health Protection Committee?

Ebola virus disease is a serious illness that originated in Africa, where there is currently an outbreak (formally declared by the World Health Organisation on March 23rd 2014). The virus causes a severe, often fatal illness in humans. It can result in uncontrolled bleeding, causing damage to internal organs. The virus is initially transmitted to humans from wild animals and is able to spread in the human population through contact with blood and bodily fluids.

For people living in countries outside Africa, the Ebola virus continues to be a very low threat. The current outbreak mainly affects three countries in West Africa: Guinea, Liberia and Sierra Leone. Around 24,282 cases and more than 9,976 deaths have been reported by the World Health Organization. This is the largest known outbreak of Ebola.

UK contingency plans for Ebola Virus Disease are based on the assumption that there is a low, but nevertheless real risk of importing a handful of further cases of EVD from West Africa in the foreseeable future.

4.1.2 Where are we now? (Current position and review of significant activity over the last 12 months)

In order to prepare for the management of a suspected case of Ebola in the Avon and Somerset Local Resilience Forum catchment, local health and resilience partners convened in September 2014 to test the local system's response. This led to a robust action plan to further strengthen existing arrangements overseen by NHS England's Emergency Planning leads.

Additionally a Local Ebola Plan produced by Public Health England and reviewed by Local Health Resilience Partners including Bristol City Council's Public Health Team is in place and has been used to manage incidents of possible cases of Ebola. Debriefs of these incidents have been convened to further share learning and keep arrangements under review.

To date, there have been no confirmed cases of Ebola resident in the Avon and Somerset catchment.

Work has been undertaken with Border Force and Port Health colleagues supporting Bristol Airport and an exercise to test Bristol City Council Port Health Plan has been scheduled.

4.1.3 Priorities for Action 2015-16: (What are we intending to do during 2015-16?)

1) Through the Health Protection Committee, the Director of Public Health for Bristol City Council will ensure that plans are in place and tested with regards to the management of a suspected case/cases of Ebola identified in Bristol.

2) The Director of Public Health for Bristol City Council will continue to work alongside Public Health England to oversee the management of Ebola related incidents and to engage with Local Resilience Forum members as required in response to the management of a suspected case / cases in the area served by the Local Authority.

5. Environmental Hazards to Health, Safety and Pollution Control

5.2 Ambient Air Quality - Avonmouth

5.2.1 Why is ambient air quality in Avonmouth a priority for Bristol and the Health Protection Committee?

Following concerns from local community members about possible exposure to environmental pollutants from industries operating in the Avonmouth Docs, The Environment Agency's Ambient Air Monitoring Team in partnership with Bristol City Council carried out a study between 8 August 2014 and 10 December 2014 (125 days) looking at air quality in this area.

5.2.2 Where are we now? (Current position and review of significant activity over the last 12 months)

The pollutants measured within the scope of this study did not breach the relevant national air quality objectives over the period considered and therefore are unlikely to impact adversely on the health of the local population.

Information provided by the Environmental Agency was presented to the local community on 3rd February 2015 attended by the MP representing this constituency. In addition, Bristol City Council's Public Health Team provided an overview of key health outcomes for this neighbourhood. Community members in attendance requested a more localised report from public health, focusing on the residential they consider to be the most affected based on geographic proximity to the industries concerning them.

5.2.3 Priorities for Action 2015-16: (What are we intending to do during 2015-16?)

1) Bristol City Council to extend the period of monitoring to ensure that at least 12 months data can be analysed.

2) Bristol City Council to further investigate further potential exposure of the local community to nuisance dust.

3) Public Health England to work collaboratively with Bristol City Council and community members to produce a localised report on the health outcomes of residents in closest proximity to the industries operating at the docs. This report will be used to inform any additional action required to reduce identified inequalities in health outcomes compared to Bristol as a whole.

Appendix 1 Immunisation schedule

Age immunised	Diseases protected against	Vaccine given
Two months old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenza* type b (Hib) Pneumococcal disease Rotavirus	DTaP/IPV/Hib and pneumococcal conjugate vaccine (PCV), Rotavirus
Three months old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenza* type b Men C Rotavirus	DTaP/IPV/Hib, MenC and Rotavirus
Four months old	Diphtheria, tetanus, pertussis (whooping cough), polio and *Haemophilus influenza* type b Pneumococcal	DTaP/IPV/Hib and PCV
Between 12 and 13 months – within a month of the first birthday	Hib Men C Pneumococcal Measles, Mumps and Rubella (MMR)	Hib/MenC, PCV and MMR
Two and three years	Influenza	Flu nasal spray (annual). If nasal spray not suitable inactivated flu vaccine will be used
Three years four months – or soon after	Diphtheria, tetanus, pertussis and polio MMR	DTaP/IPV or dTaP/IPV, MMR
Girls aged 12 to 13 years	Cervical cancer caused by human papilloma virus types 16 and 18 (and genital warts caused by types 6 and 11)	HPV
Around 14 years of age	Tetanus, diphtheria, polio and MenC	Td/IPV, MenC

Immunisation schedule for at risk children

Age Immunised	Diseases protected against	Vaccine given
At birth (to babies who are more likely to come into contact with TB than the general population)	Tuberculosis	BCG
At birth(to babies whose mothers have Hepatitis B)	Hepatitis B	Hep B
Six months to under two years	Influenza	Flu vaccine by injection (annual)
Two to 18 years	Influenza	Nasal flu vaccine (annual). If spray unsuitable inactivated flu vaccine will be used)